



GRIFFIN & VAN PELT, P.A.
Legacy Planning...For Every Family...For Everyone

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Welcome to Griffin & Van Pelt, P.A.

The following questionnaire is the most valuable tool our firm uses to begin the estate planning process. The questionnaire is quite extensive because we try to be as inclusive as possible for all personal circumstances. To make the process of filling out this questionnaire a bit easier, below are some additional instructions and information that may help.

- Print and complete by hand. Due to sensitive and personal information we do not risk your privacy.
- Use back side of your page if you need any additional room.
- Forward your completed questionnaire to our office within 24-48 hours **prior** to your scheduled consultation time. The attorney will then have time to review the information prior to your arrival which allows for a more cost efficient and productive discussion at your meeting. You have the option to return it by email, fax, mail or drop it off at the office (there is a mail slot for “after-hours” drop offs):
 1. Email: Scan the completed questionnaire to your computer and attach it to your email addressed to jennie@lawyergriffin.com
 2. Fax: (727) 446-2748.
 3. US Mail (Please allow 4-5 days for delivery):
Griffin & Van Pelt, P.A.
1455 Court Street, Clearwater, FL 33756

Should you have any further questions or need additional clarification, please do not hesitate to contact our office at 727-449-9800. We look forward to meeting with you soon!

The undersigned acknowledges that this Estate Planning Questionnaire is complete and accurate in all respects, that no information is being withheld, that Griffin & Van Pelt, P.A. can rely upon this furnished data, and that if this questionnaire is not complete, then the proposed recommendations cannot be relied upon.

Dated _____.

Client Signature



ESTATE PLANNING QUESTIONNAIRE

1)

Last	First	MI
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Other Names Known By: _____

Address: _____

Telephone: _____

Cell Phone: _____

Social Security #: _____

ID/Driver's License #
& State Issued: _____

Date of Birth: _____

Place of Birth: _____

U.S. Citizen: Yes No

If **NO**, then:

Resident Alien

Non-Resident Alien

Employed: Yes No
 Retired

Occupation
(Former if Retired): _____

If **YES**:

Company Name _____

Address _____

Have you been diagnosed with or been experiencing symptoms of any condition that has an impact on cognitive functioning and decision making (i.e. Alzheimer's/Dementia, Bi-Polar Disorder, Schizophrenia, etc.)? Yes No

Are you currently taking any medications for any health condition, memory impairment and/or any mental disorder that has an impact on cognitive functioning? Yes No

If **YES**, please list: _____

Have you been diagnosed with any other significant health issues? Yes No

If **YES**, please list: _____

Marital Status: Married* Single Widowed Divorced

Name of Spouse: _____

Years of Current Marriage: _____

Date of Current Marriage: _____

Prior Marriage(s)? Yes No

Where did you live during prior marriage(s)? _____

*Do you have a Prenuptial Agreement? Yes No

If **Yes**, please provide a copy.

Name of Long Time Prior Attorney: _____

2(a) **Children & Grandchildren.** List below the names of **children** (including adopted and/or step) and/or **grandchildren** (including adopted and/or step) in descending order (oldest to youngest). Also include their spouse's names (if applicable). **NOTE: If more space needed, please use back side of this page.**

Name	Spouse Name (if applicable)	DOB	SSN
Address		City, State	Zip
Son <input type="checkbox"/> Daughter <input type="checkbox"/> G-Son <input type="checkbox"/> G-Daughter <input type="checkbox"/>		Occupation	
Relationship to Client			

Name	Spouse Name (if applicable)	DOB	SSN
Address		City, State	Zip
Son <input type="checkbox"/> Daughter <input type="checkbox"/> G-Son <input type="checkbox"/> G-Daughter <input type="checkbox"/>		Occupation	
Relationship to Client			

Name	Spouse Name (if applicable)	DOB	SSN
Address		City, State	Zip
Son <input type="checkbox"/> Daughter <input type="checkbox"/> G-Son <input type="checkbox"/> G-Daughter <input type="checkbox"/>		Occupation	
Relationship to Client			

Name	Spouse Name (if applicable)	DOB	SSN
Address		City, State	Zip
Son <input type="checkbox"/> Daughter <input type="checkbox"/> G-Son <input type="checkbox"/> G-Daughter <input type="checkbox"/>		Occupation	
Relationship to Client			

Name	Spouse Name (if applicable)	DOB	SSN
Address		City, State	Zip
Son <input type="checkbox"/> Daughter <input type="checkbox"/> G-Son <input type="checkbox"/> G-Daughter <input type="checkbox"/>		Occupation	
Relationship to Client			

Name	Spouse Name (if applicable)	DOB	SSN
Address		City, State	Zip
Son <input type="checkbox"/> Daughter <input type="checkbox"/> G-Son <input type="checkbox"/> G-Daughter <input type="checkbox"/>		Occupation	
Relationship to Client			

Limited Partnerships		\$		
Furnishings		\$		
Motor Vehicles		\$		
Boats/Recreational Vehicles		\$		
Jewelry & Art		\$		
Other Valuable Items		\$		
Digital Assets (Kindle Books, iTunes, Amazon & PayPal Accounts, Google Docs & Photographs)		\$		
TOTAL APPROX. VALUE:	\$			

ATTORNEY ONLY: Discuss Asset Protection? Yes No Basic
 Advanced
Discuss Kearney case & implications with credit cards, bank loans, mortgage, etc. on exempt assets.

19. **Durable Power of Attorney.** This document gives financial power to your Agent to act on your behalf if you become incompetent. The powers given to your Agent cease at your death.

Name of individual you would like to act as your Agent:

Name of individual you would like to act as Successor Agent:

Do you want a pet provision which allows your Attorney-In-Fact to make payments that provide for the care of your pet(s)? Yes No

ATTORNEY ONLY: Discuss joint representation with Attorney-in-Fact if Client becomes disabled. Yes No

20. **Designation of Health Care Surrogate.** This document is to be used should you become incapacitated and allows you to name a Surrogate to make health care decisions on your behalf. The powers given to your Surrogate cease at your death.

Name of individual you would like to act as your Surrogate:

Name of individual you would like to act as Successor Surrogate:

Should your physician be advised if you are a danger to operate a vehicle? Yes No

Do you want a provision for anatomical gifts? Yes No

Do you want a pet provision which allows your pet(s) to remain with you for as long as medically advisable? Yes No

21. **Living Will.** This document enables you to direct in advance what kind of **life sustaining** medical treatments you would or would not want if you developed (1) a terminal condition, (2) an end-stage condition, or (3) you are in a persistent vegetative state and those treatment choices serve only to prolong artificially the process of dying. You are able to name Surrogates to uphold your wishes.

Name of individual you would like to act as your Surrogate:

Name of individual you would like to act as Successor Surrogate:

22(a)	Last Will and Testament. A Last Will and Testament is a declaration of your wishes to dispose of your property at your death. Discuss with attorney at consultation?			Yes <input type="checkbox"/> No <input type="checkbox"/>
22(b)	Personal Representative. Please list the names, addresses and relationship of the persons you list as Personal Representative and Successors. A Personal Representative must either be a family member OR a Florida resident.			
	NAME	ADDRESS	RELATIONSHIP	PERSONAL REPRESENTATIVE / SUCCESSOR
				<input type="checkbox"/> Personal Representative
				<input type="checkbox"/> Successor #1
				<input type="checkbox"/> Successor #2

22(c)	Guardian. If you have minor children, please list the names, addresses, and relationship of the person(s) you wish to serve as Guardian. Individuals can be named to be the Guardian of the person (the child him/herself), the tangible personal property (the "Property") and/or the Homestead.			
	NAME	ADDRESS	RELATIONSHIP	WILL SERVE AS GUARDIAN FOR
				<input type="checkbox"/> Person <input type="checkbox"/> Property <input type="checkbox"/> Homestead
				<input type="checkbox"/> Person <input type="checkbox"/> Property <input type="checkbox"/> Homestead
				<input type="checkbox"/> Person <input type="checkbox"/> Property <input type="checkbox"/> Homestead

22(d)	Pet Provisions. Do you want a pet provision which provides for the care of your pets during your lifetime and at your death? If YES, then to whom do you devise your pets? (Please list below the person's name and relationship to you). _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
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22e)	Devising Personal Residence. How do you want to devise your personal residence:		
	To Children?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	To a specific person or charity?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Direct sale of your personal residence?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	ATTORNEY ONLY: Explain Save Our Home Cap and Creditor Issues	Yes <input type="checkbox"/> No <input type="checkbox"/>	

22f) **Separate Writing.** A Separate Writing can be completed if you desire any tangible personal property be devised to a particular individual or individuals. This becomes part of your original will. Discuss with attorney at your consultation? Yes No

22g) **Additional Distributions.** Please indicate below the individual(s) to whom you wish the remainder of your estate assets to be distributed.

NAME	ASSET(S)	PERCENTAGE/SHARE

22h) **Charitable Contributions.** Please list any religious, charitable or other organization(s) you want to receive any portion of your estate.

NAME OF ORGANIZATION	CONTACT NAME & ADDRESS	AMOUNT OR ITEM	TO BE USED FOR?

23a) **Trust Documents.** Discuss with attorney? Yes No

23b) **Trustee.** Please list the names, addresses and relationships of the persons you wish to serve as your Trustee and Successor Trustees.

NAME	ADDRESS	RELATIONSHIP	TRUSTEE / SUCCESSOR
			Initial Trustee <i>(at your death or incapacity)</i>
			Successor #1

			Successor #2
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23c)	Corporate Trustee. Do you authorize a Corporate Trustee to invest in affiliated services and products?	Yes <input type="checkbox"/> No <input type="checkbox"/>
<p>PLEASE NOTE: If you name an out-of-state trustee, you should consider state income tax consequences. If a trustee resides in Arizona, California, Delaware, Georgia, Hawaii, New Hampshire, New Mexico, Oregon, or Virginia, please check with a CPA regarding that state's income tax.</p>		

23d)	Distributions. Please indicate below the individual(s) to whom you wish the remainder of your estate assets to be distributed.		
	NAME	ASSET(S)	PERCENTAGE/SHARE

23e)	Married Beneficiaries. Do you want to include a provision requiring a beneficiary to have a prenuptial or postnuptial agreement in order to receive a distribution from trust assets to protect the beneficiary from their spouses if there is a dissolution of marriage?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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23f)	Substance Abuse. Do you want a provision withholding or redirecting distributions if any beneficiary suffers from an addiction (i.e. substance, gambling, etc.) or is/has been incarcerated?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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23g)	Designated Representative. Do you want a provision in the trust nominating a person who can represent and bind a beneficiary (without the beneficiary's knowledge) and receive any notice, information, accounting, or report on behalf of the beneficiary?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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24)	Additional Information. List any other information you feel may be helpful in the analysis of your estate plan which has not been covered herein:
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25)	Location of Original Documents. Do you want your original documents kept at the office of Griffin & Van Pelt, P.A. for safekeeping?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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If NO , please indicate where you intend to store your original documents: _____	
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